

Date: _____

Patient's Name: _____

Last

First

Middle

Home Address: _____

City: _____ State: _____ Zip Code: _____

Telephone: Home: _____ Work: _____ Cell: _____

Social Security Number: _____ - _____ - _____ Birthdate: _____ Age: _____ M / F

Occupation: _____

Employer: _____

Employer's Address: _____

City: _____ State: _____ Zip Code: _____

In case of an EMERGENCY, contact: _____ Relation: _____

Home: _____ Work: _____ Cell: _____

Were you referred by: Physician(Please List): _____

:Other _____

Primary Insurance

Name of Insurance: _____

Policy Number: _____ Group Number: _____

Primary Insured: _____ Relation: _____

Social Security Number: _____ - _____ - _____ DOB: _____

Insured Employer: _____

Insured Employer's Address: _____

City

State

Zip

[IF SECONDARY INSURANCE IS NEEDED FOR MEDICARE PATIENTS, IS THE POLICY PAID BY SELF OR EMPLOYER (Please fill out Secondary Information on the back of this form.)]

Financial

1. Office Visits and Consultations are payable on the day that you are seen.
2. Cosmetic procedures are always payable on the day of service.
3. All COPAYS and DEDUCTIBLES are due at the time of service. It is illegal to waive these fees.
4. If we participate with your insurance company, we will file the claim for you.
5. If your insurance requires a referral, IT IS YOUR RESPONSIBILITY to have a valid referral in this office EACH time you are seen.
6. If an appointment is not cancelled 24 hrs prior, a \$25 fee may be applied.

I understand that I am financially responsible for all charges for services to me, including the balance remaining after payment of the insurance benefits. I authorize payment of medical payments directly to Dr. Rotter, and I authorize the release of any medical or other information necessary to process my claim(s). I also accept responsibility for any legal fees and collection agency charges which may be occurred if I fail to pay all balances due within 90 days of service. I permit a copy of this authorization to be used in place of the original.

Signature: _____

Date: _____

Patient or Responsible Party

ASSIGNMENT OF BENEFITS: I hereby authorize payment directly to Dr. Rotter for medical insurance benefits otherwise payable to me under the terms of my policy(s). In making this assignment, I understand and agree that I am financially responsible to Dr. Rotter for charges not paid under the insurance policy(s). I permit a copy of this authorization to be used in place of the original.

SELF-PAY PATIENT: Payment in full is required at the time of visit, for all services rendered. Payment can be by cash, personal check, credit card or debit card.

Authorization: _____
Patient or Responsible Party

Medicare Subscribers

I request that payment of authorized Medicare benefits be made on my behalf to Center for Medical Dermatology, PLLC for any services furnished to by Center for Medical Dermatology, PLLC. I authorize any holder of medical information about me to release to the Health Care Finance Administration and its agents any information needed to determine these benefits or the benefits payable for related services. I also realized if there is another insurance company I am required to furnish this information for billing purposes. If Medicare is my primary insurance carrier, Center for Dermatology, PLLC accepts assignment and I will be bill according to the regulations set by the Health Care Finance Administration.

I request that payment of authorization benefits be made on my behalf to Center for Medical Dermatology, PLLC for any services furnished to me. I authorize any holder of Medicare information about me to release to the above named insurance company any information needed to determine these benefits payable for these or related services.

Signature of Beneficiary: _____
Patient or Responsible Party

Secondary Insurance for Medicare Patients

Name of Insurance: _____
Policy Number: _____ **Group Number:** _____
Primary Insured: _____ **Relation:** _____
Social Security Number: _____ - _____ - _____ **DOB:** _____
Insured Employer: _____
Insured Employer's Address: _____

City State Zip